



Medical and Health Insurance Information Form

Student's name _____

Medical History

Please indicate the childhood illnesses your student has had and complete the information about your child's current physical condition. **If your student has not had that illness or condition, please check the "No" box.**

Childhood illness

	Yes	No	Date
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	
German Measles	<input type="checkbox"/>	<input type="checkbox"/>	
Measles	<input type="checkbox"/>	<input type="checkbox"/>	
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	
Shingles	<input type="checkbox"/>	<input type="checkbox"/>	

Allergies

	Yes	No	Date
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	
Insect Sting Reaction	<input type="checkbox"/>	<input type="checkbox"/>	
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>	
Poison Ivy, etc.	<input type="checkbox"/>	<input type="checkbox"/>	

Current physical conditions

	Yes	No	Date
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	
Bleeding/Clotting Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Convulsions/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Frequent Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Defect/Disease	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Vision Impairment	<input type="checkbox"/>	<input type="checkbox"/>	

Food Allergies (Please list)

Medication Allergies (Please list)

Other Allergies (Please list)

Mobility Difficulties (Please explain)

Vision Difficulties (Please explain))

Health Information (Please attach additional paper if necessary)

Has the student been under any medical care within the past three months? If so, explain.

Explain any treatment the student has received in the past for his/her physical, mental or emotional health.

Is the student on a special diet? If so, explain.

Should the student be restricted in recreation or swimming? In what way?

Is there anything else we should know about your child, or any other special needs he or she may have?

Health Insurance Information

My student has health insurance

Name of insurance carrier _____

Policy or group number _____

Name of policy owner (Insured) _____

In addition

I assume full responsibility for payment of medical expenses that are not covered by my insurance and are incurred as a result of my student's participation in the Explore Your Future program.

Parent/Guardian signature _____ Date _____

My student does not have health insurance

I assume full responsibility for payment of medical expenses incurred as a result of my student's participation in the Explore Your Future program.

Parent/Guardian signature _____ Date _____

In case of emergency

First contact name _____

Day phone: (_____) _____ Night phone: (_____) _____

Second contact name _____

Day phone: (_____) _____ Night phone: (_____) _____

Permission Slip and Consent for Medical Treatment (Parent/Guardian)

This health history is correct as far as I know. I give permission for my child to participate in all prescribed program activities except as noted above on this form.

I also give permission for _____ (print student's name) to be given first aid in case of emergency while he/she is in attendance at the EYF program. This includes permission for the child to be taken to the emergency department of a local hospital if the injury is serious enough to require medical attention. I hereby waive and release all responsibilities and anyone involved in the EYF program of any liabilities or claims in association with anything that might occur while my child is attending the program. I verify all information I have provided to be true and correct.

Parent/Guardian signature _____ Date _____

Authorization to Use or Disclose Health Information for TechGirlz Participants

HIPAA Statement for Medical and Health Insurance Information

Parent or guardians,

Any authorization you provide to TechGirlz and RIT regarding the use and disclosure of your child's medical and health information may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your child's medical and/or health information for the reasons you describe. Please note that TechGirlz is required to retain and maintain records of your child's care until September 30, 2009.

I give permission for TechGirlz program staff and employees of Rochester Institute of Technology to use and/or disclose protected health and medical information about my child's _____,
(name of child) medical or other health conditions in order to carry out necessary treatment.

Camper's name (please print): _____

Camper's signature: _____ Date: _____

Parent/guardian's name (Please print) _____

Parent/guardian's signature _____ Date _____